Report of Termination of Disability and/or Payment

U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs



1. Name of Injured Employee (last, first, middle) 2. Social Security Number 3. OWCP File Number (If known) 4. Department or Agency 5. Bureau or Office 6. Name and Address of Reporting Office (Include Zip Code) 7. Date and Hour of Injury (Mo., day, year) AM PM				Office of Works	3 Compensation in	grams	
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6. Name and Address of Reporting Office (Include Zip Code) 7. Date and Hour of Injury (Mo., day, year) AM PM 8. Date and Hour Stopped Work (Mo., day, year) AM PM 11. Employee's Work Week On Return To Duty, If Other Than Monday Through Friday S M T W T F S 12. Present Pay Rate If Different From That Received At Time Employee Stopped Work. a. Base Pay b. Subsistence c. Quarters d. Other (Specify) S M T W T F S 13. Inclusive Dates Employee's Received Pay For Any Part of The Period of Absence Because of: a. Annual Leave b. Sick Leave c. Other (Specify) From: From: From: From: Through: 14. Has Employee's Work Assignment Been Changed Because of Disability Resulting From This Injury? Yes No If Yes, Describe The Type of Work Employee Is Performing. 15. If Interrupted, Show Dates Deductions For Health Benefit Optional Insurance Were Resumed (Mo., day, year) Health Benefit Optional Insurance Were Resumed (Mo., day, year) 16. If Health Benefit Option Has Changed Since Disability Began, Show New Code Number and Date of Change (Mo., day, year) Number Date 17. Remarks 19. Show The Gross Dollar Amount Of Regular Pay Which The Employee Received Of Disability. Do not include pay received for sick leave or annual leave.	Name of Injured Employee (last, first, middle)			2. Social Security Number			
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